January 27, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Transparency in Coverage (CMS-9915-P)

Dear Administrator Verma:

On behalf of the Arizona Hospital and Healthcare Association and our more than 80 hospital, healthcare and affiliated health system members, thank you for the opportunity to offer comments on the Centers for Medicare & Medicaid Services (CMS) Proposed Rule for Transparency in Coverage.

In the rule, the Departments of the Treasury, Labor, and Health and Human Services (collectively, the departments) propose to require health plans to provide their enrollees individualized information on their expected cost-sharing liability for a health care event, as well as other important information about their coverage. In addition, health plans would be required to publicly disclose their negotiated rates and allowed amounts for all in-network and out-of-network providers.

We are deeply committed to ensuring patients have the information they need to make informed health care decisions, especially timely, accurate estimates of their cost-sharing liability. **We appreciate that the first policy proposed would help further this objective and look forward to working with the departments on this shared goal. However, we strongly disagree with the additional proposal requiring health plans to publicly release their negotiated rates. Instead of helping patients, this policy could lead to widespread confusion and even more consolidation in the commercial health insurance industry and should be abandoned.**

Disclosure of Personalized Cost-sharing Information

The departments seek comment on their proposal requiring health plans to provide enrollees individualized information on their expected cost-sharing liability for a health care event, as well as other important information about their coverage. We commend the departments for putting forth a policy that would help patients gain better access to timely, accurate and personalized information on their expected cost-sharing and other important coverage details.

In particular, we support the departments' attention to helping patients understand the full extent of their coverage, including where they are in their deductible and any coverage prerequisites**. We encourage the departments also to require health plans to make this information available to providers.** Patients reasonably turn to providers for this information when contemplating or scheduling health care services, but providers often face barriers in accessing the necessary details from insurers to provide a timely, accurate estimate. Specifically, we encourage the departments to require health plans to enable provider access to patients' specific benefit information via a secure website.

We also appreciate the departments' acknowledgement that the estimates may not reflect the amount ultimately charged to the patient and support the inclusion of this key point in the proposed model disclosure notice. In some cases, the course of care can be unpredictable, and, therefore, patients should be aware of the limitations of estimates provided prior to care delivery.

Public Disclosure of Negotiated Rates and Allowed Amounts

The departments also seek comment on their proposal to require health plans to make their negotiated rates and allowed amounts publicly available. Public disclosure of such sensitive information would confuse – not help – patients in understanding their potential cost-sharing liability and would severely disrupt private contract negotiations between providers and health plans. In addition, the departments' proposal to require health plans to broadly and publicly disclose negotiated rates information violates both the Affordable Care Act (ACA) and the Administrative Procedure Act (APA).

Lack of Statutory Authority Under the ACA. On its face, the departments' proposal suffers from a clear, basic, and overriding flaw: the absence of a nexus to its purported underlying statutory authority. The proposed disclosure requirement does not further the statutory objective of promoting transparency in *coverage*. The departments, therefore, lack the legal authority to compel the public disclosure of such highly sensitive and confidential pricing information.

The departments rely in the first instance on section 1311(e)(3) of the ACA as their purported authority to compel broad and public disclosure of negotiated rates information.[1] Section

[1] A separate statutory provision at section 2715A of the Public Health Service Act (PHSA) provides that all other non-grandfathered health plans must also "comply with the provisions of section 1311(e)(3) . . . except that a plan or coverage that

1311(e)(3) is titled "Transparency in coverage" and provides that each health insurance exchange must "require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, [and] the State insurance commissioner, and make available to the public," eight statutorily enumerated types of information related to coverage (e.g., claims payment policies and practices, periodic financial disclosures, data on enrollment).[2] Section 1311(e)(3) also includes a catch-all provision that requires disclosure of "[o]ther information as determined appropriate by the Secretary."[3] The departments assert that negotiated rates are "other information" that is a proper subject of disclosure under the catch-all provision.[4]

As section 1311(e)(3)'s heading, as well as its context, make clear, however, *all* of the information subject to disclosure under section 1311(e)(3) must be related to "[t]ransparency in *coverage*."[5] This means that, where the Secretary designates "other information" for disclosure under section 1311(e)(3)'s catch-all provision, that other information must further transparency in coverage, just as the statutorily enumerated types of information do.

The departments cannot lawfully require disclosure of negotiated rates information under section 1311(e)(3) because it relates to *price* – not coverage. While the departments attempt to link the two by stating that the negotiated rates are a necessary input for some cost-sharing calculations, this is itself a concession that the disclosure of negotiated rates information, in and of itself, furthers only *price* transparency, as opposed to the statutorily required objective of promoting *coverage* transparency. Moreover, the departments' separate proposal mandating the disclosure of estimated cost-sharing liability and accumulated financial responsibility[6] means that the disclosure proposed here does nothing to further promote cost-sharing transparency in this regard.

In addition, the departments are proposing to require public disclosure of information that the departments themselves are statutorily required to protect against such disclosure. As the departments themselves recognize,[7] negotiated rates are typically held as "trade secrets" or other "confidential commercial information." Congress has enacted robust statutory regimes, such as the Trade Secrets Act, the Privacy Act, and the Freedom of Information Act (FOIA), that expressly protect such highly sensitive and confidential information from public disclosure

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is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public." PHSA § 2715A (codified at 42 U.S.C. § 300gg-15a). As discussed below, this provision does *not* expand the scope of the disclosures that may be required under section 1311(e)(3).

[2] Section 1311(e) of the ACA is codified at 42 U.S.C. § 18031(e)(3).

[3] 42 U.S.C. § 18031(e)(3)(ix).

[4] 84 Fed. Reg. 65,464, 65,477 (Nov. 27, 2019).

[5] 42 U.S.C. § 18031(e)(3) (emphasis added); *see generally Almendarez-Torres v. United States*, 523 U.S. 224, 234 (1998) ("'[T]he title of a statute and the heading of a section' are 'tools available for the resolution of a doubt' about the meaning of a statute.") (citing *Trainmen v. Baltimore & Ohio R. Co.*, 331 U. S. 519, 528–29 (1947)).

[6] *See* 84 Fed. Reg. at 65,472.

[7] *See* 84 Fed. Reg. at 65,510.

when it is obtained by the Government.[8] The departments are now proposing to require health plans to publicly disclose the very same types of information that the departments are statutorily prohibited from making public. The departments may not compel third parties to do indirectly what the departments themselves may not do directly.[9]

APA Violation. The reasoning on which the departments rely on to support their proposal reveals that the proposal is arbitrary and capricious in violation of the APA. The departments rely on five justifications for requiring broad and public disclosure of negotiated rates information:

- First, the departments assert that uninsured consumers will use negotiated rate information to select health care service providers.[10]
- Second, the departments assert that negotiated rate information will be used by individuals who wish to "evaluate available options [in the] group or individual market."[11]
- Third, the departments assert that public disclosure of negotiated rates "is necessary to enable consumers to use and understand price transparency data in a manner that will increase competition, reduce disparities in health care prices, and potentially lower health care costs."[12]
- Fourth, the departments assert that requiring public disclosure of negotiated rates will help employers that sponsor group health plans in rate negotiation.[13]
- Fifth, the departments assert that requiring public disclosure of negotiated rates will "assist health care regulators in . . . oversee[ing] health insurance issuers."[14]

None of these justifications pass muster under the APA and all rely on statutorily improper considerations or are otherwise indefensible. Indeed, the first four justifications offered by the departments are not even grounded in statutorily cognizable considerations. All four justifications are ultimately premised on the departments' conjecture that the proposed disclosure of pricing information will better let consumers "judge the reasonableness of provider prices and shop for care at the best price."[15] As discussed above, this argument relies

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[8] *See, e.g.*, 5 U.S.C. § 552(b)(4) (exempting trade secrets and confidential commercial or financial information from public disclosure under FOIA), 5 U.S.C. § 552(a) (Privacy Act); 18 U.S.C. §1905 (Trade Secrets Act); *see also* 18 U.S.C. § 1836 (Defend Trade Secrets Act of 2016, recognizing the intellectual property rights of trade secret holders).

[9] *Cf. Cummings v. Missouri*, 71 U.S. 277, 288 (1867) ("[T]hat what cannot be done directly cannot be done indirectly; or as [Sir Edward] Coke has it, . . . '*Quando aliquid prohibetur, prohibetur et omne, per quod devenitur ad illud*.'"); *cf.* 82 Reg. Reg. 37,990, 38,499 (Aug. 14, 2017) (withdrawing a proposal to require third parties to disclose confidential survey reports because the proposal "may appear as if [the Centers for Medicare & Medicaid Services] was attempting to circumvent the [statutory] provision" that prohibits the agency from directly disclosing such reports).

[10] 84 Fed Reg. at 65,477.

[11] *Id.*

[12] *Id.* at 65,478.

[13] *Id.*

[14] *Id.* at 65,479.

[15] 84 Fed. Reg. at 65,477.

on the flawed premise without a meaningful linkage to the statutory objective of "[t]ransparency *in coverage*."[16]

These first four justifications are also misplaced because they are not grounded in any rationale applicable to *qualified health plans* (QHPs). Section 1311(e)(3) of the ACA concerns transparency in coverage under health plans seeking certification as QHPs from a health insurance exchange.[17] Thus, any disclosure requirement must first find a basis in furthering transparency in coverage under QHPs. Accordingly, the departments may *not* rely on their proffered rationales relating to the uninsured,[18] employers that sponsor group health plans,[19] consumers shopping more broadly for health insurance coverage beyond QHPs,[20] or governmental health benefit programs[21] – or vague and speculative pronouncements about alleged benefit to the health care system generally – to justify their proposal.[22]

Finally, the departments cannot rationally conclude that their proposal will benefit health care consumers. If anything, requiring disclosure of negotiated rates information is likely to *compound* confusion among consumers rather than promote more informed decision-making.

The departments' fifth proffered rationale is invalid as well. The departments cannot justify *public* disclosure of highly sensitive and confidential pricing information on the grounds that state insurance regulators might find such information helpful. To begin with, as the departments have conceded,[23] state regulators already have access to this information. Furthermore, to the extent that the departments were interested in providing such information to state regulators, they could invoke alternative authorities, such as sections 1322(c)(1) and 1321(a)(1) of the ACA, which would avoid public disclosure. Finally, even under section 1311(e)(3) of the ACA, "[t]he Exchanges shall . . . make available to the public…other information" only "*as determined appropriate* by the Secretary."[24] Here, the Secretary has properly determined that the "other information" at issue (i.e., the negotiated rates information) is "appropriate" to be made available *only* to state regulators.

First Amendment Violation. The departments' proposal to mandate the disclosure of highly confidential and commercial sensitive negotiated rate information also constitutes compelled speech in violation of the First Amendment to the United States Constitution. Government regulation of non-misleading commercial speech is unlawful unless it "directly advances" a "substantial" governmental interest, and is no "more extensive than is necessary to serve that

[16] 42 U.S.C. § 18031(e)(3) (emphasis added).
[17] *See* 42 U.S.C. § 18031(e)(3) (requiring health insurance exchanges to impose requirements on "health plans seeking certification as qualified health plans").
[18] 84 Fed. Reg. at 65,477.
[19] *Id.* at 65,478–79.
[20] *Id.* at 65,477.
[21] *Id.* at 65,477–78.
[22] *See, e.g.*, *id.* at 65,465–68, 65,477–78.
[23] 84 Fed. Reg. at 65,479.
[24] 42 U.S.C. § 18031(e)(3) (emphasis added).

interest."[25] Here, the departments' proposal to mandate public disclosure of negotiated rates does not advance any substantial governmental interest, much less in a narrowly tailored way.

In conclusion, while we are deeply committed to ensuring patients have the information they need to make informed health care decisions including accurate estimates of their cost-sharing liability, we strongly disagree with requiring health plans to publicly release their negotiated rates for all the legal and practical reasons discussed in this letter.

Sincerely,

Debbie Johnston
Senior Vice President, Policy Development

[25] *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of New York*, 447 U.S. 557, 566 (1980). Certain uncontroversial commercial disclosures may be required consistent with *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626 (1985). But the departments have failed to identify a sufficient predicate to justify the application of *Zauderer* to the facts presented here. In any event, the proposed rule here would fail under either test. Even under *Zauderer,* a disclosure requirement cannot be "unjustified or unduly burdensome." *Id.* at 651.